

8082

## CERTIFICATE OF DEATH

Reg. Dist. No. 290...

## 1. PLACE OF DEATH:

COUNTY

Tallot

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

40

TOWN

Easton

LENGTH OF STAY  
(in this place)

30 days

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

80

Memorial Hospital

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Md.

COUNTY

Tallot

CITY (If outside corporate limits, write RURAL and give nearest town)  
OR

TOWN

McDaniel

STREET  
ADDRESS

(If rural give location)

1

3. NAME OF  
DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

Charles

N.

Adams

## 4. DATE (Month)

(Day)

(Year)

OF  
DEATH: 8

15

1955

## 5. SEX:

M

6. COLOR OR  
RACE:

Black

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED.  
(Specify):

Widowed

## 8. DATE OF BIRTH:

May 9

1874

## 9. AGE last birthday

81

yrs.

## IF UNDER 1 YEAR

## IF UNDER 24 HRS.

Months

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired):

Janitor

10B. KIND OF BUSINESS  
OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

Maryland

12. CITIZEN OF WHAT  
COUNTRY?

U. S. A

## 13. FATHER'S NAME

William Adams

## 14. MOTHER'S MAIDEN NAME:

Sara Drake

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.)

unk.

16. SOCIAL SECURITY NO.  
(If Yes, give war or dates  
of service)

## 17. INFORMANT &amp; ADDRESS:

Dorothy Blacke (friend)

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

155X

IMMEDIATE CAUSE

## ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

(A)

Exhaustion

DUE TO

(B)

C.A. of G.B. &amp; Liver

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION:

July 27 -

## 19B. MAJOR FINDINGS OF OPERATION

Inoperable C.A. of G.B. &amp; Liver

## 20. AUTOPSY?

YES

NO

21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)  
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

M.

21E. INJURY OCCURRED  
While ☐ Not while ☐  
at work at work

## 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/15, 1955, to 8/15, 1955, that I last saw the deceased

alive on 8/15, 1955, and that death occurred at 8:30 P.M., from the causes and on the date stated above.

SIGNATURE

M. N. Palmer

M.D.

ADDRESS

Easton Md

DATE SIGNED

8 19 55

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

Burial

## DATE THEREOF

8/19/55

## NAME OF CEMETERY OR CREMATORY

Charles

## LOCATION (City, town, or county)

Charles Md

(State)

DATE RECD BY LOCAL  
REGISTER

8/16/55

## REGISTRAR'S SIGNATURE

N. H. Nevers &amp; B. Ashwell - Easton Md

## 24. FUNERAL DIRECTOR

## ADDRESS

MARGIN RESERVED FOR BINDING

RECEIVED

AUG 22 1955

BUREAU V. S.

8083

## CERTIFICATE OF DEATH

Reg. Dist. No. 290...

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Talbot</u>	MARYLAND	STATE <u>MD.</u>	COUNTY <u>Talbot</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Easton</u>	LENGTH OF STAY (in this place) <u>Life</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Easton</u>	<u>40</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Glenwood Ave ext.</u>		STREET ADDRESS (If rural give location) <u>Glenwood Ave. Ex. 1</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Myrtle Bantum</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>August 16</u> 195 <u>5</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>12/24/11</u>
9. AGE last birthday <u>43</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Sales</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Joseph Johns</u>		14. MOTHER'S MAIDEN NAME: <u>Emma Ennels</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Virginia Brooks, Easton, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
2041 IMMEDIATE CAUSE (A) <u>Myelogenous Leukemia</u>			<u>18 Mo +</u>
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(B)			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Aug 10</u> , 195 <u>5</u> , to <u>Aug 16</u> , 195 <u>5</u> , that I last saw the deceased alive on <u>August 5</u> , 195 <u>5</u> , and that death occurred at <u>11:55 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>W. F. Buell</u>		DATE SIGNED <u>Aug 18, 1955</u>	
M. D. <u>Easton Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>8/20/55</u>	<u>Chapel Cem</u>	<u>New Chapel Md.</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>8/18/55</u>	<u>W. R. Neuner</u>	<u>James B. Ashfield</u>	<u>Easton, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 22 1955

RECEIVED

8101

## CERTIFICATE OF DEATH

Reg. Dist. No. 291

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>TALBOT</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>TALBOT</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>NEAVITT</u>		<u>30</u>		OR TOWN <u>NEAVITT</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH:			
(First) <u>WILLIAM</u> (Middle) (Last) <u>BERNHARD</u>				(Month) <u>AUG</u> (Day) <u>31</u> (Year) <u>1953</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>AUG 8, 1878</u>	<u>77</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
<u>WATERMAN</u>			<u>SEAFOOD</u>		<u>GERMANY</u>		<u>U.S.A.</u>
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>John BERNHARD</u>				<u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>NO</u>		<u>NO</u>		<u>214-34-7352 Mrs. Grace Bernhard Neavitt Md</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							<u>3-4 wks</u>
Immediate cause (a) <u>uremia</u>							
DUE TO							
Antecedent cause(s) (b) <u>Bilateral ureteral obstruction</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>carcinoma of the bladder</u>							
DUE TO							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. <u>generalized cachexia</u>							
19a. DATE OF OPERATION:			19b. MAJOR FINDINGS OF OPERATION:				20. AUTOPSY?
							Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY)	(STATE)
		INJURY					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>9-5</u> , 19 <u>54</u> , to <u>8-31</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8-31</u> , 19 <u>55</u> , and that death occurred at <u>12:05 A.</u> m., from the causes and on the date stated above.							
SIGNATURE				(DEGREE OR TITLE) ADDRESS		DATE SIGNED	
<u>[Signature]</u>				<u>MD St Michael's Md.</u>		<u>8-31-55</u>	
23. BURIAL, CREMATION REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept 2, 1955</u>		<u>Neavitt Cemetery</u>		<u>Neavitt Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Sept 2, 1955</u>		<u>Mrs. R. K. [Signature]</u>		<u>Hambleton Harrison, St. Michael's Md</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 8 1955

RECEIVED



8084

## CERTIFICATE OF DEATH

Reg. Dist. No. 290...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		LENGTH OF STAY (in this place) <u>12 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Preston</u> <u>05X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hos.</u>				STREET ADDRESS (If rural give location) <u></u>			
3. NAME OF DECEASED: (Type or Print) <u>William Henry Boevers</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>8</u> <u>31</u> <u>1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH: <u>May 5 - 1874</u>	9. AGE last birthday: <u>81</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>carpenter</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u></u>		11. BIRTHPLACE (State or foreign country): <u>Europe</u>	
12. CITIZEN OF WHAT COUNTRY: <u>USA</u>							
13. FATHER'S NAME: <u>Mr Henry Boevers</u>				14. MOTHER'S MAIDEN NAME: <u>Martha Bo Augustin Lampke</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u></u> (If Yes, give war or dates of service) <u></u>				16. SOCIAL SECURITY NO.: <u>215-16-9249</u>		17. INFORMANT & ADDRESS: <u>Mr Louis Boevers</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Myocardial infarction</u>							
ANTECEDENT CAUSE (B) <u>Myocardial infarction</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <u>atherosclerotic coronary thrombosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9 Aug</u> , 19 <u>53</u> , to <u>31 Aug</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>31 Aug</u> , 19 <u>55</u> , and that death occurred at <u>9:05 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Thomson Harrison</u>				DATE SIGNED <u>9/1/55</u>			
23. BURIAL, CREMATION, RECOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>9-1-55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>	
DATE REC'D BY LOCAL REGISTRAR <u>9/1-55</u>				REGISTRAR'S SIGNATURE <u>N.H. Neuman</u>		24. FUNERAL DIRECTOR <u>Harry Hollis</u> ADDRESS <u>Preston, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 16 1955

BUREAU V. S.



8085

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Talbot</i>	MARYLAND	STATE <i>md.</i>	COUNTY <i>Talbot</i>
CITY (If outside corporate limits, write RURAL or give nearest town) TOWN <i>40 Easton</i>	LENGTH OF STAY (If this place) <i>6 days</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Easton, md. R. 1</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Memorial Hospital, Easton</i>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last) <i>Edward Roland Christopher</i>		4. DATE (Month) (Day) (Year) OF DEATH: <i>Aug 6 1955</i>	
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>Dec 1, 1903</i>
9. AGE last birthday <i>51</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Bridge Tender</i>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Wm. R. Christopher</i>		14. MOTHER'S MAIDEN NAME: <i>Jessie Hopkins</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>yes</i>		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT & ADDRESS: <i>Mrs. Marilla A. Christopher (wife)</i>		18. MEDICAL CERTIFICATION <i>Easton, md.</i>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <i>Heart failure</i>			
ANTECEDENT CAUSE (S) (B) <i>Arterio-sclerotic Heart Disease</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>19</i> , to <i>19</i> , that I last saw the deceased alive on <i>8-6-55</i> , and that death occurred at <i>8:05 A.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Edw. Schmitt</i>		DATE SIGNED <i>15 August 1955</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>8-8-55</i>	
NAME OF CEMETERY OR CREMATORY <i>Lincolnton</i>		LOCATION (City, town, or county) (State) <i>near Preston Md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>8-7-55</i>		REGISTRAR'S SIGNATURE <i>M. R. Meeres</i>	
24. FUNERAL DIRECTOR <i>J. J. Trampton</i>		ADDRESS <i>in Federalsburg md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 17 1955

BUREAU V. S.

8086

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <i>Talbot</i>		MARYLAND	STATE <i>Maryland</i> COUNTY <i>Talbot</i>		
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Easton</i>		LENGTH OF STAY (In this place) <i>40 yrs.</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Easton</i>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural give location) <i>1</i>		
3. NAME OF DECEASED: (Type or Print) <i>Regina Shield Clark</i>			4. DATE (Month) (Day) (Year) OF DEATH: <i>Aug 10 1955</i>		
5. SEX: <i>F.</i>	6. COLOR OR RACE: <i>W.</i>	7. SINGLE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH: <i>Aug 30, 1887</i>		9. AGE last birthday: <i>67</i> yrs
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housekeeper</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Own Home</i>	11. BIRTHPLACE (State or foreign country): <i>Decatur County, Ga</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME: <i>Richard W. Shield</i>			14. MOTHER'S MAIDEN NAME: <i>Charlotte Sig. Stewart</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS: <i>Mr Harry E. Clark, Easton</i>		
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
IMMEDIATE CAUSE (A) DUE TO <i>Myocardial Infarction</i>					<i>Sudden</i>
ANTECEDENT CAUSE (B) DUE TO <i>Arteriosclerotic Coronary Disease</i>					<i>1 yr</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>1931</i> , to <i>8/10/1955</i> , that I last saw the deceased alive on <i>8/5/1955</i> , and that death occurred at <i>1:20</i> M, from the causes and on the date stated above.					
SIGNATURE <i>B. Coe</i>		ADDRESS <i>Easton</i>		DATE SIGNED <i>8/11/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Aug 12, 55</i>	NAME OF CEMETERY OR CREMATORY <i>Spring Hill</i>		LOCATION (City, town, or county) <i>Easton</i>
DATE REC'D BY LOCAL REGISTRAR <i>8-11-55</i>		REGISTRAR'S SIGNATURE <i>N.H. Neer</i>		24. FUNERAL DIRECTOR <i>W. H. Clark</i>	
				ADDRESS <i>Easton</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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8087

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Talbot</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Queen Anne</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
40 TOWN <i>Easton, Md.</i>		<i>Days</i>		OR TOWN <i>Chester Md 178-2</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Easton Memorial Hospital</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<i>Mary Estelle Gardner</i>				OF DEATH: <i>8-11-1955</i>			
5. SEX.	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH.	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>Female</i>	<i>White</i>	<i>Widowed</i>	<i>May 3, 1900</i>	<i>55</i> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>H.W.</i>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>Maryland</i>	
13. FATHER'S NAME: <i>William E. King</i>				14. MOTHER'S MAIDEN NAME: <i>Drucilla Collick</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <i>Admission Sheet Mr John A. Gardner Chester, Md (P.O.)</i>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
410X IMMEDIATE CAUSE (A) <i>2 1/2 1/2 1/2</i>							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>11 1/2</i> to <i>19</i> , that I last saw the deceased alive on <i>11 1/2</i> , 19 <i>1955</i> , and that death occurred at <i>11 1/2</i> A.M. from the causes and on the date stated above.							
SIGNATURE		M. D.		ADDRESS		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		DATE THEREOF <i>AUG. 13 '55</i>		NAME OF CEMETERY OR CREMATORY <i>STEVENSVILLE CEMETERY</i>		LOCATION (City, town, or county) (State) <i>STEVENSVILLE, MARYLAND</i>	
DATE REC'D BY LOCAL REGISTRAR <i>8-13-55</i>		REGISTRAR'S SIGNATURE <i>M. A. Neenan</i>		24. FUNERAL DIRECTOR <i>Edgar L. Loney</i>		ADDRESS <i>CHURCH HILLS MD.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				08091	
tem 18 Film G185 8-19-55 am				Reg. Dist. No. 290	
8102					
1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Talbot</u>		MARYLAND	STATE <u>Md.</u>		COUNTY <u>Talbot</u>
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)		
X TOWN <u>Easton, Rural</u>			OR TOWN <u>Easton, Rural</u> X		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural give location)		
68			1		
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE (Month) (Day) (Year)		
DECEASED: (Type or Print) <u>Philip Francis Goldsborough</u>			OF DEATH: <u>Aug. 11, 1955</u>		
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>May 1, 1893</u>	9. AGE last birthday: <u>62 yrs. 3 Months 11 Days</u>	IF UNDER 1 YEAR: <u>3</u> Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farming Truck Farming</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Lincoln Georgia</u>	12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>	
13. FATHER'S NAME: <u>McKenzie Goldsborough</u>			14. MOTHER'S MAIDEN NAME: <u>Julia Fleming</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT & ADDRESS: <u>Herbert H. Balch, Easton Md.</u>		
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
IMMEDIATE CAUSE (A) <u>Gunshot wound, head,</u>					
ANTECEDENT CAUSE (B) <u>self inflicted</u> SUICIDE					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.					
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1955</u> , to <u>1955</u> , that I last saw the deceased alive on <u>1955</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.					
SIGNATURE <u>Thurston Harrison</u>		M.D. <u>Easton Maryland</u>		DATE SIGNED <u>2/10/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug 13, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery, Easton, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>8/10/55</u>		REGISTRAR'S SIGNATURE <u>N. H. Heeres</u>		24. FUNERAL DIRECTOR ADDRESS <u>John D. Williams, Easton, Md.</u>	



8088

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Salisbury</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Salisbury</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>		LENGTH OF STAY (in this place) <u>1 day 2 hrs 20 min</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dilghman</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hosp.</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (First) <u>Gregory</u> (Middle) <u>Guy</u> (Last) <u>Haddaway</u>				4. DATE (Month) <u>8</u> (Day) <u>18</u> (Year) <u>1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>		8. DATE OF BIRTH: <u>8-16-55</u>	
9. AGE last birthday: <u>1</u> yrs <u>1</u> months <u>21</u> days <u>30</u> min.				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:			
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME: <u>Edward Haddaway</u>				14. MOTHER'S MAIDEN NAME: <u>Frances Pritchett</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>no</u>				16. SOCIAL SECURITY NO.:			
17. INFORMANT & ADDRESS: <u>Mr. Edward Haddaway (father)</u>				INTERVAL BETWEEN ONSET AND DEATH			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Congenital Heart Disease</u>							
ANTECEDENT CAUSE (B) <u>Absence of Circulation</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <u>Patent Ductus arteriosus</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
21C. WHERE DID (City or town) (County) (State)				21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3:35</u> 19 <u>19</u> , to <u>18 Aug 1955</u> , that I last saw the deceased alive on <u>18 Aug 1955</u> and that death occurred at <u>3:35</u> A. M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>18 Aug 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>Aug 19</u>			
NAME OF CEMETERY OR CREMATORY <u>Dilghman</u>				LOCATION (City, town, or county) <u>Dilghman, Indist Md</u>			
DATE REC'D BY LOCAL REGISTRAR <u>8-18-55</u>				REGISTRAR'S SIGNATURE <u>N. H. Neer</u>			
24. FUNERAL DIRECTOR <u>[Signature]</u>				ADDRESS <u>[Address]</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



8089

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Tacket</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Tacket</i>
CITY (If outside corporate limits, write RURAL and give nearest town). OR TOWN <i>Carlton</i>	LENGTH OF STAY (in this place) <i>5 yrs.</i>	CITY (If outside corporate limits, write RURAL and give nearest town). OR TOWN <i>Carlton</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <i>27 N. Hanson St.</i>	
3. NAME OF DECEASED.		4. DATE (Month) (Day) (Year)	
(First) <i>May</i>	(Middle) <i>Paula</i>	(Last) <i>Kimmon</i>	DATE OF DEATH: <i>Aug 31 1955</i>
5. SEX: <i>F.</i>	6. COLOR OR RACE: <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>Aug 13, 1881</i>
9. AGE last birthday: <i>74</i> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housekeeper</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Clean Home</i>	
11. BIRTHPLACE (State or foreign country): <i>Tacket County</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME: <i>Charles Taylor Paulsby</i>		14. MOTHER'S MAIDEN NAME: <i>Mary Ann Smithers</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) (If Yes, give war or dates of service): <i>No</i>		16. SOCIAL SECURITY NO. <i>✓</i>	
17. INFORMANT & ADDRESS: <i>Mr. Dorothy Kim, Carlton, Md</i>			
I MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
332X IMMEDIATE CAUSE (A) <i>Cerebral Artery Thrombosis due to</i>			
ANTECEDENT CAUSE (B) <i>Cerebral atherosclerosis</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <i>250X</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Diabetes mellitus</i>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH? (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <i>after</i> <i>26 Aug</i> , 1955, to <i>31 Aug</i> , 1955, that I last saw the deceased alive on <i>26 Aug</i> , 1955, and that death occurred at <i>M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Dorothy Kim</i>		DATE SIGNED <i>2 Sept 55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Sept 2, 55</i>	
NAME OF CEMETERY OR CREMATORY <i>Spring Hill</i>		LOCATION (City, town, or county) <i>Carlton</i>	
DATE REC'D BY LOCAL REGISTRAR <i>9/2/55</i>		REGISTRAR'S SIGNATURE <i>N.H. Neerux</i>	
24. FUNERAL DIRECTOR <i>W. H. Neerux</i>		ADDRESS <i>Carlton, Md</i>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. E.

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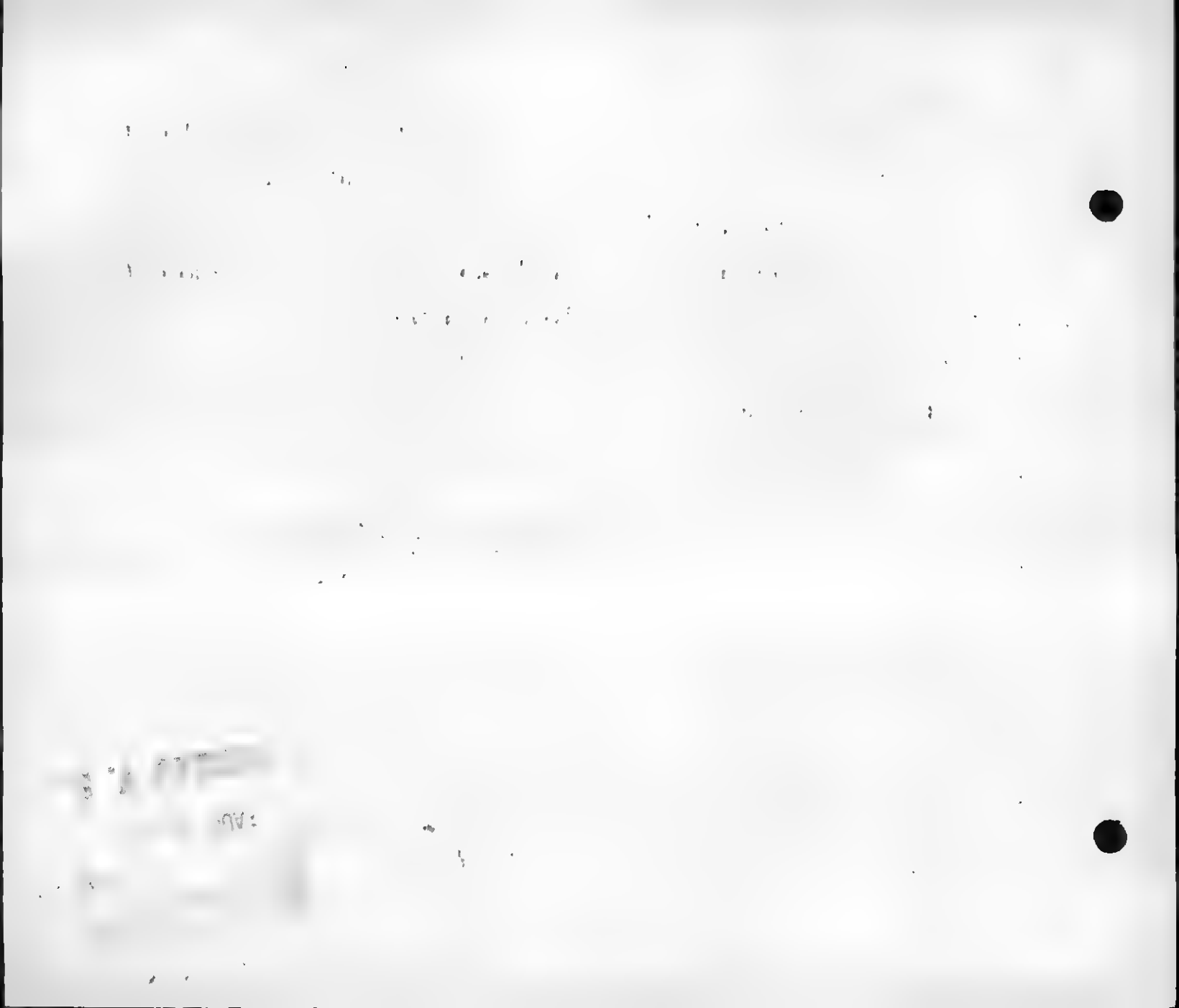
## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <u>Talbot</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Easton</u> LENGTH OF STAY (in this place) <u>3 days</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Talbot</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Claiborne</u> STREET ADDRESS (If rural give location) <u>1</u>	
3. NAME OF DECEASED: (First) <u>Margaret</u> (Middle) <u>Sindsay</u> (Last) 4. DATE (Month) (Day) (Year) OF DEATH: <u>August 18, 1955</u>		5. SEX: <u>F</u> 6. COLOR OR RACE: <u>W</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>m</u> 8. DATE OF BIRTH: <u>June 26, 1897</u> 9. AGE last birthday: <u>58</u> yrs. <u>12</u> Months <u>18</u> Days <u>1</u> Hours <u>1</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>H.W.</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>MD.</u>	
11. BIRTHPLACE (State or foreign country): <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME: <u>Thomas Nash</u>		14. MOTHER'S MAIDEN NAME: <u>Addie Emmert</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Mr. George A. Lindsay (husband)</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE <u>cardiac failure</u> ANTECEDENT CAUSE (S) <u>mediastinal tumor metastasis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>adenocarcinoma base of tongue</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>6 mos</u> <u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 1952</u> to <u>Aug. 1955</u> , that I last saw the deceased alive on <u>18 Aug. 1955</u> , and that death occurred at <u>6:35 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u> M. D. <u>Dr. Michael</u> ADDRESS <u>St. Michaels, Md.</u> DATE SIGNED <u>8-18-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> DATE THEREOF <u>Aug. 22</u> NAME OF CEMETERY OR CREMATORY <u>Olivet Cemetery</u> LOCATION (City, town, or county) (State) <u>St. Michaels, Md.</u>			
DATE REC'D BY LOCAL REGISTRAR <u>8-19-55</u> REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR ADDRESS <u>[Signature] St. Michaels, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

8091

2411 N. Charles Street, Baltimore

09096

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH- COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Caroline	
CITY (If outside corporate limits, write RURAL and give nearest town) Easton		CITY (If outside corporate limits, write RURAL and give nearest town) Preston	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Easton Memorial Hospital		STREET ADDRESS Main	
3. NAME OF DECEASED (First) Daniel (Middle) Walter (Last) Morris		4. DATE OF DEATH (Month) 8 (Day) 27 (Year) 1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 6/3/1905
9. AGE last birthday 50 yrs.		10. If under 1 year 1 year 11. If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Police		10b. KIND OF BUSINESS OR INDUSTRY Police	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME John Wesley Morris		14. MOTHER'S MAIDEN NAME Margaret Jane Lee	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. 221-02-5560	
17. INFORMANT AND ADDRESS Fannie A. Morris		Preston, Md.	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
480.0 Immediate cause (a) Cerebral embolism			
Antecedent cause(s) (b) Arteriosclerotic condition			5 wks
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Arteriosclerotic condition			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 27 Sept, 1953, to 27 Oct, 1955, that I last saw the deceased alive on 27 Oct, 1955, and that death occurred at 11:00 a.m., from the causes and on the date stated above.			
SIGNATURE (Degree or title) Fannie A. Morris M.D.		ADDRESS Preston, Maryland	
DATE SIGNED 6 Sept 55			
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE August 31	
NAME OF CEMETERY OR CREMATORY Jr. O. U. A. M.		LOCATION (City, town, or county) Preston Md.	
DATE REC'D BY LOCAL REG. 8-30-55		REGISTER'S SIGNATURE M.H. Neer	
24. FUNERAL DIRECTOR Harry M. Hollis		ADDRESS Preston, Md.	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 10



Item 9, Film 186 9-8-55 et **CERTIFICATE OF DEATH**Reg. Dist. No. **291**

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>talbot</b>	MARYLAND	STATE <b>md</b>	COUNTY <b>talbot</b>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>McDaniel</b>	LENGTH OF STAY (in this place) <b>Life</b>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>McDaniel</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00</b>		STREET ADDRESS (If rural give location) <b>1</b>	

3. NAME OF DECEASED:			4. DATE (Month) (Day) (Year)		
(First) <b>Annie</b>	(Middle) <b>M.</b>	(Last) <b>Murphy</b>	DEATH: <b>8-27 1955</b>		
5. SEX: <b>Female</b>	6. COLOR OR RACE: <b>Col.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Widowed</b>	8. DATE OF BIRTH: <b>9/3/04</b>		
9. AGE last birthday: <b>51</b> yrs			10. IF UNDER 1 YEAR: Months Days		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Cook</b>			10B. KIND OF BUSINESS OR INDUSTRY: <b>Domestic</b>		
11. BIRTHPLACE (State or foreign country): <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY: <b>U.S.A.</b>		
13. FATHER'S NAME: <b>Rufus Murray</b>			14. MOTHER'S MAIDEN NAME: <b>Rachel Moody</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service):			16. SOCIAL SECURITY NO.		
17. INFORMANT & ADDRESS:					

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
171X IMMEDIATE CAUSE	(A) <b>Squamous cell ca. metastatic-generalized</b>	?
ANTECEDENT CAUSE (B)	(B) <b>Squamous cell ca. cervix</b>	?
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C)
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>cachexia-generalized</b>		-
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **4-7-55** to **8-27-55** that I last saw the deceased alive on **8-27-55**, and that death occurred at **5 A.M.** from the causes and on the date stated above.

SIGNATURE <b>[Signature]</b>	ADDRESS <b>M.D. Smith Md. 8-29-55</b>	DATE SIGNED <b>8-29-55</b>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	DATE THEREOF <b>8/28/55</b>	NAME OF CEMETERY OR CREMATORY <b>Clashmore Cem.</b>
LOCATION (City, town, or county) (State) <b>Clashmore, Md.</b>	24. FUNERAL DIRECTOR <b>James B. Doshill</b>	ADDRESS <b>Easton, Md.</b>
DATE REC'D BY LOCAL REGISTRAR <b>Aug 29, 1955</b>	REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MARGIN RESERVED FOR BINDING

V.S. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
AUG 31 1965  
BUREAU V. S.

Heiser



8792

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Talbot</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Caroline</u>
CITY (If outside corporate limits, write RURAL or and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Denton</u>	<u>MD</u> <u>5 x 2</u>
40 TOWN <u>Easton Md.</u>	12 days	STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hospital.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Wingate</u> <u>Neal</u>		OF DEATH: <u>Aug</u> <u>23</u> <u>1955</u>	
5 SEX	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8 DATE OF BIRTH:
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Dec 10, 1898</u>
9. AGE last birthday	10. MONTHS	11. YEARS	12. IF UNDER 24 HRS. Hours Min.
<u>56</u>			
10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>FARMER</u>		10B KIND OF BUSINESS OR INDUSTRY: <u>FARMING</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME: <u>E. Wingate Neal</u>		14. MOTHER'S MAIDEN NAME: <u>Laura Andrew</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16 SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Mrs Edna Neal (Wife)</u>		18. MEDICAL CERTIFICATION	
		1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
421.1		(A) IMMEDIATE CAUSE	
		(B) ANTECEDENT CAUSE (S)	
		DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	
		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>19</u> , to <u>19</u> , that I last saw the deceased alive on <u>23</u> , 1955, and that death occurred at <u>8:45</u> A.M. from the causes and on the date stated above.		DATE SIGNED	
SIGNATURE <u>[Signature]</u>		ADDRESS <u>Denton, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Burial</u>		<u>Aug. 26, 1955</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Denton</u>		<u>Denton, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR	
<u>8-24-55</u>		ADDRESS <u>[Signature]</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1000000000

1000000000

1000000000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8992				080927			
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 290.							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Talbot		MARYLAND		STATE Maryland		COUNTY Caroline	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN			
TOWN Easton		2 days		Ridgely - Rural 05X-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
Memorial Hospital				Tuckahoe Neck Road			
3. NAME OF DECEASED: (Type or Print)		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
EMMA		Virginia Nichols		August 3		1955	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Female	Colored	Widowed	Oct. 7, 1880	74 yrs.	Months	Days	Hours   Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Housework		Home		Caroline County, Maryland		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Thomas Chase				Mary Catherine Smith			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
No		None		Mrs. Viola Ewing, Ridgely, Md., R.F.D.			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
400.0 Immediate cause (a)..... Shock							2 days
Antecedent cause(s) (b).....							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c).....							
Fractured Lumbar Vertebra							2 days
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21c. (City or town) (County) (State)			
		Home					
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
8 3 55 12 PM				Fell down stairs			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		M. D.		CHIEF MEDICAL EXAMINER		DATE SIGNED	
L. J. George				DEPUTY MEDICAL EXAMINER		8/6/55	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Aug. 7, 1955		Bell's Chapel Cemetery		Near Denton, Maryland	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
8-4-55		N. H. Neer		J. J. Frampton and Son, Federalsburg, Md.			

AUG 1

8094

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 290

1. PLACE OF DEATH- COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Talbot</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Easton</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Easton, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hosp.</u>				STREET ADDRESS <u>(If rural, give location)</u>			
3. NAME OF DECEASED (Type or Print)		(First) <u>Lee</u>		(Middle) <u>Tripp</u>		(Last) <u>Norris</u>	
4. DATE OF DEATH		(Month) <u>August</u>		(Day) <u>28</u>		(Year) <u>1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Nov 18, 1936</u>		9. AGE last birthday <u>18</u> yrs.	10. under 1 year Months   Days   Hours   Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student Nurse</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Union Mem. Hosp</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>				13. FATHER'S NAME <u>Richard I. Norris</u>			
14. MOTHER'S MAIDEN NAME <u>Sleanor H. Tripp</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT AND ADDRESS <u>Mr. Richard I. Norris father</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
822X Immediate cause (a) <u>Laceration of brain</u>							
Antecedent cause(s) (b) <u>Auto accident</u>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH				PLACE (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
(CITY OR TOWN) <u>Easton</u>				(COUNTY) <u>Talbot</u>			
(STATE) <u>Md.</u>				TIME (Month) (Day) (Year) (Hour) <u>8 28 53 1955</u>			
INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>				HOW DID INJURY OCCUR? <u>Pass. in car which overturned</u>			
22. I certify that I took charge of the remains described above, held an Autopsy Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>							
SIGNATURE <u>Louis M. Mott</u>				DATE SIGNED <u>8-29-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				DATE THEREOF <u>8/30/55</u>			
NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>				LOCATION (City, town, or county) <u>Easton Md.</u>			
DATE RECD BY LOCAL REG. <u>8/29/55</u>				24. FUNERAL DIRECTOR <u>John W. Sullivan</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SEP 11 1964

SEP 11 1964

SEP 11 1964

## 8095 CERTIFICATE OF DEATH

Reg. Dist. No. 290...

## 1. PLACE OF DEATH:

COUNTY Talbot

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)  
OR  
TOWN EastonLENGTH OF STAY  
(in this place)  
17 mo 40 m 11HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESSMemorial Hospital

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MDCOUNTY TalbotCITY (If outside corporate limits, write RURAL and give nearest town)  
OR  
TOWN EastonSTREET  
ADDRESS

(If rural give location)

321 South Street3. NAME OF  
DECEASED  
(Type or Print)

(First)

(Middle)

(Last)

BadleyBayParker

## 4. DATE (Month)

(Day)

(Year)

OF  
DEATH8291955

## 5. SEX:

6. COLOR OR  
RACE:7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify): Single

## 8. DATE OF BIRTH

## 9. AGE last birthday

IF UNDER 1 YEAR

IF UNDER 24 HRS.

maleB8-28-55

yrs

Months

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired):10B. KIND OF BUSINESS  
OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT  
COUNTRY?MarylandU.S.A.

## 13. FATHER'S NAME:

## 14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates  
of service)

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT &amp; ADDRESS

No

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

76.5

## IMMEDIATE CAUSE

(A)

Alelectasis

## ANTECEDENT CAUSE (S):

DUE TO

PrematurityDISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION:

## 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)  
INJURY OCCUR? (County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

M.

21E. INJURY OCCURRED  
While ☐ Not while ☐  
at work at work

## 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from

, 19 , to , 19 , that I last saw the deceased

alive on  
SIGNATURE, 19 , and that death occurred at: 20 AM, from the causes and on the date stated above.

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL  
REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

8-30-55N.H. NewerJames B. Harris

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 6

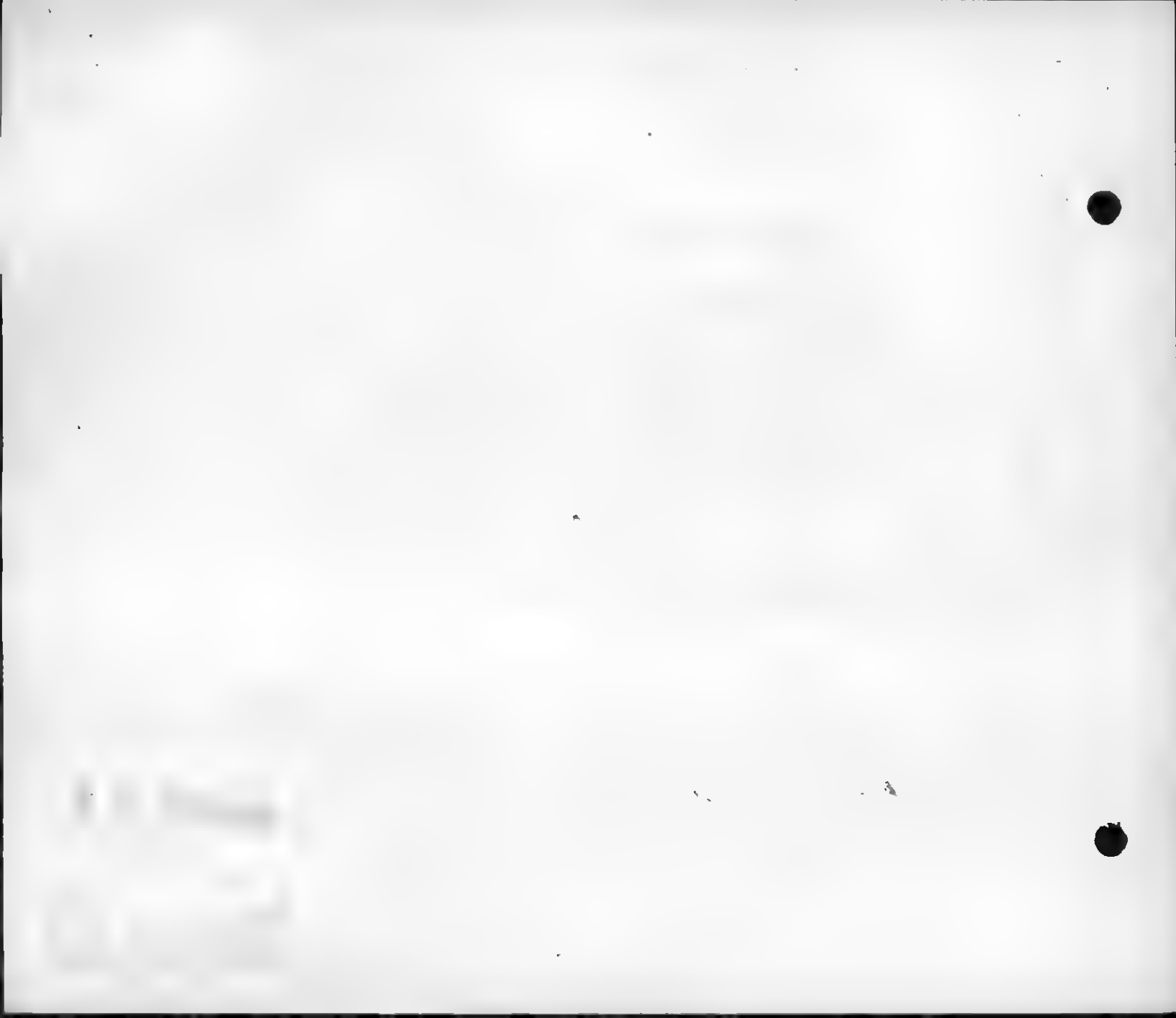
RECEIVED



## 8096 CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Lacoste</u>		MARYLAND		STATE <u>md.</u> COUNTY <u>Lacoste</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Easton</u>		LENGTH OF STAY (in this place) <u>10 hours</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Preston</u>		<u>05 X. 21</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Edward</u> <u>Plutschak</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>Aug 31</u> <u>19 55</u>			
5. SEX. <u>M</u>		6. COLOR OR RACE. <u>W.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):		8. DATE OF BIRTH: <u>June 22, 1874</u>	
				9. AGE last birthday: <u>81</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Germany</u>			
11. BIRTHPLACE (State or foreign country): <u>Germany</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME: <u>Gottlieb Plutschak</u>				14. MOTHER'S MAIDEN NAME: <u>Wilhelmina Wagner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO			
17. INFORMANT & ADDRESS: <u>Mrs. Augusta Plutschak</u>							
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Acute Left Ventricular Failure</u>				<u>10 hours</u>			
ANTECEDENT CAUSE (B) <u>Arteriosclerotic Hypertension and Cor Arteriosclerotic</u>				<u>10 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>October 1, 1944</u> , to <u>8/31</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/3</u> , 19 <u>55</u> , and that death occurred at <u>2<sup>30</sup></u> PM, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		ADDRESS <u>[Address]</u>		DATE SIGNED <u>9/2/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-3-1955</u>		NAME OF CEMETERY OR CREMATORY <u>J.O.U.A.M.</u>		LOCATION (City, town, or county) (State) <u>Preston Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>8-31-55</u>		REGISTRAR'S SIGNATURE <u>N.H. Devereux</u>		24. FUNERAL DIRECTOR <u>Harry Rollins</u>		ADDRESS <u>Preston Md.</u>	



## 8097 CERTIFICATE OF DEATH

Reg. Dist. No. 290...

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED.			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Easton</u>		LENGTH OF STAY (in this place) <u>reg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>40 00</u>				STREET ADDRESS (If rural give location) <u>40 1</u>			
3. NAME OF DECEASED: (Type or Print) <u>Frank B. Ross</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Aug 19 1955</u>			
5. SEX: <u>M.</u>		6. COLOR OR RACE: <u>W.</u>		7. SINGLE <input type="checkbox"/> MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH: <u>Aug 8, 1884</u>	
				9. AGE last birthday <u>71</u> yrs		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>3</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Agent Bld. Mutual</u>		11. BIRTHPLACE (State or foreign country): <u>Talbot County, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Robert Edward Ross</u>				14. MOTHER'S MAIDEN NAME: <u>Annie Cullen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.: <u>010-10-4902</u>		17. INFORMANT'S ADDRESS: <u>H. B. Ross, Jr. Glen Burnie, Md</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
527.1 IMMEDIATE CAUSE							
(A) DUE TO <u>Acute respiratory acidosis</u>						12 hrs.	
ANTECEDENT CAUSE (B)							
(B) DUE TO <u>Pulmonary emphysema</u>						2-1	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>002X</u>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic TBC</u>						12 mo.	
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/16</u> , 19 <u>53</u> , to <u>17 Aug 1955</u> , that I last saw the deceased alive on <u>19 Aug 55</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Theresa Lancia</u>				DATE SIGNED <u>22 Aug 55</u>			
M. D. <u>Carlton</u>							
23. BURIAL CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Aug 27, 55</u>		<u>Spring Hill</u>		<u>Easton</u>		<u>MD</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. PUBLIC HEALTH DIRECTOR		ADDRESS	
<u>8-20-55</u>		<u>N. H. Nelson</u>		<u>Alfred</u>		<u>Easton</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

44



JOHN A. S. A.

500

1000

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8192

8098

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>md.</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
TOWN <u>Easton</u>		<u>13 days</u>		TOWN <u>Easton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial</u>				STREET ADDRESS (If rural give location) <u>A. F. D. #2</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Emma</u> <u>Stewart</u>				<u>Aug - 8</u> <u>19 55</u>			
5. SEX. <u>F</u>	6. COLOR OR RACE. <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH: <u>May 8, 1876</u>	9. AGE last birthday: <u>79</u> yrs	IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY: <u>H. W.</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Mr. William D. Stithberg</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah A. Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT & ADDRESS: <u>Kenneth Stewart SON</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cs of Rectum</u>						<u>6 mo</u>	
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						<u>metastases to liver</u>	
(B) DUE TO							
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1955 to 8/21, 1955</u> that I last saw the deceased alive on <u>8/8</u> , 19 <u>55</u> and that death occurred at <u>2 40 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS <u>Easton md</u>			
				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug 10, 55</u>		<u>Spring Hill</u>		<u>Easton</u> <u>MD</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>8-9-55</u>		<u>[Signature]</u>		<u>[Signature]</u>		<u>Easton</u>	



## 8099 CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Talbot</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Dorchester</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hurlock</u> <u>09X-2</u>	
TOWN <u>Easton</u>	<u>16 days</u>	STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>		—	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH	
<u>Vernon Williams</u>		<u>Aug 2, 1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>May 5-1878</u>
9. AGE last birthday: <u>77</u> yrs		10. IF UNDER 1 YEAR: Months <u>16</u> Days <u>16</u> Hours <u>16</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY: <u>Retired</u>	11. BIRTHPLACE (State or foreign country): <u>Md.</u>
13. FATHER'S NAME: <u>J. Albert Williams</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
14. MOTHER'S MAIDEN NAME: <u>Laura V. Wright</u>		17. INFORMANT & ADDRESS: <u>Mrs. Katherine C. Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
450.0 IMMEDIATE CAUSE		(A) <u>Pericardial edema</u>	
ANTECEDENT CAUSE (S)		(B) <u>Heart failure</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C) <u>Arteriosclerosis</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Supra-pubic contusion</u>			
19A. DATE OF OPERATION: <u>20 June 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Enlarged prostate</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>7/17</u> , 19 <u>55</u> , to <u>8/2</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8/2</u> , 19 <u>55</u> , and that death occurred at <u>4:45 PM</u> from the causes and on the date stated above.			
SIGNATURE: <u>[Signature]</u>		ADDRESS: <u>Centon</u> DATE SIGNED: <u>Aug 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>Buried</u>		<u>Hurlock</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>8-3-55</u>		24. FUNERAL DIRECTOR ADDRESS: <u>22 Hampton Lane Federalburg Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 188104

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>TALBOT</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Laroline</u>	
CITY (If outside corporate limits, write OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
40 TOWN <u>EASTON</u>	62 days	<u>Hickman</u> <u>05X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
80 <u>EASTON Memorial Hosp.</u>			
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Harvey</u>	(Middle) <u>Wooters</u>	OF DEATH: <u>9</u> <u>14</u> <u>1956</u>	
(Type or Print)			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>May 27 - 1891</u>
		9. AGE last birthday: <u>64</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
		<u>MARYLAND</u>	<u>United States</u>
13. FATHER'S NAME: <u>?</u>	14. MOTHER'S MAIDEN NAME: <u>Marie Thorpe</u>	17. INFORMANT & ADDRESS: <u>MR Ira Wooters - Greenwood Del.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.		
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
592X IMMEDIATE CAUSE (A) <u>Drum. due to chronic glomerul. nephritis</u>			
ANTECEDENT CAUSE (B) <u></u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) <u></u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>April</u> , 19 <u>55</u> , to <u>May</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 11</u> , 19 <u>55</u> , and that death occurred at <u>11:50</u> PM, from the causes and on the date stated above.			
SIGNATURE <u>Harvey Wooters</u>		ADDRESS <u>Cathy, Maryland</u>	DATE SIGNED <u>May 11, 1955</u>
M. D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>8/18/55</u>	<u>Wesley Burial Ground</u>	<u>Bearsville Md.</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>8-15-55</u>	<u>N.A. Neerues</u>	<u>J.E. Boula</u>	<u>Greensboro Md.</u>

RECEIVED

AUG 23 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08105

8104

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Talbot		MARYLAND		STATE Md.		COUNTY Balto. Co.	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X TOWN Easton (Rural)		3 yrs.		Baltimore 20X-1			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH			
(First) Mary		(Middle) Etta		(Last) Wright		Aug. 8 19 55	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Female	white	widowed	April 26, 1868	87 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
housewife				Baltimore, Md.		U. S.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Thomas McGill				Emily Bowdle			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.):		16. SOCIAL SECURITY NO.:		17. INFORMANT & ADDRESS:			
no		none		Mrs. Irene Garey			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE						yes.	
ANTECEDENT CAUSE (S):						yes.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
(A) Multiple Small Cerebral Hemorrhages							
DUE TO							
(B) General Arteriosclerosis							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY?				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-1-1953, to 8-8-1955, that I last saw the deceased alive on 8-8-1955, and that death occurred at 100 M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
H. F. Bevel		M. D. 19 Goldsboro Rd. Easton, Md.		8-9-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
burial		Aug. 10, 1955		Spring Hill Cemetery		Easton, Talbot Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
8-9-55		H. F. Bevel		Maurice E. Newnam & Son		Easton, Md.	

BUREAU V. S.

AUG 11 1955

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